UTILIZATION REVIEW REPORT

INTRODUCTION

Under the provisions of the Multipurpose Senior Services Program's (MSSP) Home- and Community-Based Services (HCBS) Waiver and the State Medicaid Plan, the program is required to establish and maintain a system of Utilization Review (UR). The authority to conduct these reviews is found in the following sources:

Federal – Title XIX, Social Security Act, Section 1915 I; 42 Code of Federal Regulations (CFR), Section 456; Federal Home- and Community-Based Services Waiver.

State – Welfare and Institutions (W&I) Code, Section 14170; Title 22 California Code of Regulations, Title XXII, Section 51346; Interagency Agreement #01-15976 between Department of Health Care Services (DHCS) and California Department of Aging (CDA) and CDA policies.

The CDA conducts collaborative and independent URs to monitor the program at the site level for compliance with the Waiver, the Interagency Agreement (IA) between CDA and DHCS, and CDA MSSP policies. Currently, each site is scheduled to be reviewed every other year. The objectives of the CDA UR process are to:

1. Verify the medical necessity of services provided to eligible MSSP clients funded by the HCBS Waiver.

2. Ensure that available resources and services are being used efficiently and effectively.

3. Identify problem areas and to provide technical assistance (TA) as needed.

4. Initiate corrective action(s), if warranted.

The process followed by the CDA UR team involves a review of pertinent documentation, procedures and processes; consultation and discussion with staff; and a home visit to a client. The specific areas addressed by this report are:

1. NECESSITY OF SERVICES: Client Eligibility and Level of Care (LOC).

2. CLIENT ENROLLMENT, RIGHTS, AND INFORMATION: Application, Client Enrollment /Termination Information Form (CETIF), Notification of Rights, Authorization for Use and Disclosure of Protected Health Information Form (AUDPHI), Institutionalization Form (IF).

3. APPROPRIATENESS OF SERVICES: Initial Health Assessment (IHA), Initial Psychosocial Assessment, Reassessment (IPSA), Care Plan, Assessing and Documenting Client Risk, Progress Notes, and Case Record.

4. AUTHORIZATION AND UTILIZATION OF SERVICES: Service Planning and Utilization Summary (SPUS), Tracking Cost Effectiveness, and Vendor Agreement Review.

5. QUALITY ASSURANCE ACTIVITIES: Peer/Internal Review, Client Satisfaction Survey and Home Visit.

METHODOLOGY

Review Date:	June 7, 2010 through June 10, 2010
Review Site:	Multipurpose Senior Services Program 301 South State Street Ukiah, California 95482
Record Review:	Twenty case records, six of which were terminated. Ten vendor files.
Review Period:	November 2008 through December 2009
CDA-MSSP Review Team:	Vicki Cabassi, Nurse Evaluator II Gloria Abernethy, Program Analyst II Jennifer Friedrich, Program Analyst II
Scheduled Conferences:	Entrance: June 7, 2010; Exit: June 10, 2010
Conference Participants:	Dennis Fay, Site Director Stephanie Husted, Supervising Care Manager (SCM) Elaine Heine, SCM Pam Lyssand, Social Worker Care Manager (SWCM) Annie Callaway, SWCM Linda Dake, Data Support David Anderson, Administrative Assistant

DEFINITION OF TERMS

1. Findings:
   - Conclusions reached after the UR. Documents site practices during the review period. Compares what exits at the site with what is required.

2. Recommendations:
   - Actions necessary to correct existing conditions or improve operations and practices. The recommendations indicated in this report are requirements not suggestions.

3. Technical Assistance:
   - Documents information provided to site staff during UR. Includes consultation on specific client cases, printed information, online resources, policy references, etc. TA may also document subsequent research and responses provided to site staff following the UR.

4. Corrective Action:
   - Remediates problems found in site practices and ensures compliance to MSSP policies including the federal Waiver and the current Contract. A Corrective Action Plan (CAP) includes but is not limited to the following:

     - Revision of the site's existing procedures and practices or development of new ones. The site shall submit written documentation describing these changes.

     - Training of site staff necessary to implement the required CAP. Training documentation to be submitted to CDA may include, but is not limited to, the following:
       - Schedule of in-service sessions and dates;
       - Sign-up sheet or roster of session attendees;
       - Agenda or syllabi of sessions (topics covered);
       - Name of person(s) conducting the sessions;
       - Session hand-outs; and
       - Synopses of session results including specific problem areas addressed.

     - Periodic submittals to CDA, which may include examples of redacted case record documents, such as care plans, assessment forms, progress notes, etc., produced following the required training and remediation.

CORRECTIVE ACTION PLAN

A CAP is required as specified in the following UR Findings. A CAP is required to ensure compliance with the listed findings and recommendations. Please submit to CDA within 30 days. CDA reviewers may attend scheduled in-service training sessions developed in conjunction with the CAP without notice.

I. NECESSITY OF SERVICES

The objective of the MSSP is to avoid, delay, or remedy the inappropriate placement of persons in nursing facilities, while fostering independent living in the community. At a cost lower than nursing facility placement, MSSP provides services to eligible clients and their families to enable clients to remain in or return to their homes. Case record documentation must support the client's need for these services.

Reference: MSSP Site Manual

I. A. Client Eligibility

Eligibility for the program is addressed initially at screening and confirmed throughout participation in the program. MSSP eligibility criteria include all of the following:

- Age 65 or older;
- Residence in the catchment area;
- Receiving Medi-Cal under an appropriate code;
- Certifiable for placement in a nursing facility (refer to the LOC section of this report for criteria requirements);
- Ability to be served within the cost limitations of MSSP and
- Appropriate for care management services.

Reference: MSSP Site Manual

Findings:

The LOC in client record #XXXX was not completed within the required timeframe. The enrollment date was XXXX XX, XXXX; however, the LOC was completed three days later on XXXX XX, XXXX.

Recommendations:

Incorporate the following TA into site policies and procedures.

Technical Assistance

In order to be enrolled in MSSP, clients must be certifiable for placement in a nursing facility as described in the LOC; therefore, the LOC must coincide with or precede enrollment.

Corrective Action:

The findings did not constitute trends; therefore, a CAP is not required.

I. B. Level of Care

The LOC determination is a clinical judgment made by the NCM. The LOC is a timely analysis of information gathered to determine and verify that the client is certifiable for placement in an Intermediate Care Facility (ICF) or Skilled Nursing Facility (SNF). The body of the client's case record must support the LOC determination.

References: California Code of Regulations, Title 22, and MSSP Site Manual

Findings:

Ten of twenty client records reviewed (#XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) contained LOCs that did not fully describe the client's functional status.

Nine of twenty client records reviewed (#XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) contained LOCs that did not describe the type or level of assistance the client required to complete activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

Five of twenty client records reviewed (#XXXX, #XXXX, #XXXX, #XXXX and #XXXX) contained LOCs that focused on service needs rather than a description of the client's functional limitations.

Two client records (#XXXX and #XXXX) addressed all IADLs except telephone use.

Two client records (#XXXX and #XXXX) did not indicate if the source of information was obtained from a client visit or a record review.

The XXXX XXXX LOC in client record #XXXX did not include the use of an assistive device, a XXXX XXXX XXXX.

Client record #XXXX contained an LOC that inappropriately included documentation regarding XXXX XXXX XXXX.

Recommendations:

Incorporate all technical assistance provided during the review and in this report. Implement instruction acquired during the May 13, 2010 CDA LOC training into site policies and procedures to ensure LOC documentation is followed according to program requirements. Within 60 days from the date of this report, the site must submit, to CDA for review, two LOCs from each NCM along with the associated Re/assessment summary and Functional Needs Assessment Grid (FNAG). The LOCs will be reviewed by CDA and additional technical assistance will be provided, as necessary.

Technical Assistance:

When completing LOCs, the Nurse Care Manager (NCM) must focus their analysis and judgment on the following elements:

- cognition,
- level of assistance required to perform IADLs, (hands-on, verbal cueing or stand-by),
- use of assistive devices, and
- how medical conditions affect the client's ability to function.

Review MSSP Site Manual Section 3.110.3 Application of Title 22 Criteria and 3.110.5 Completion of LOC Certification Sheet which states, "The LOC certification form must be completed to certify the LOC requirement..." and indicate the source of information (client visit or record review). This validates that the client meets the eligibility criteria "certifiable for placement in a nursing facility."

MSSP budget concerns have nothing to do with a client's functional status and therefore should not be included in any LOC.

A LOC tool with examples was provided during the exit conference.

Corrective Action:

A CAP is required.

II. CLIENT ENROLLMENT, RIGHTS AND INFORMATION

II. A. Application

The application form is the vehicle for applying for services and summarizes what a client can expect from MSSP, alternatives regarding services and the rights of program participants. The application must be completed prior to conducting the LOC determination, and a copy of the application must be provided to the client.

References: California Code of Regulations, Title 22, and MSSP Site Manual

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

II. B. Client Enrollment/Termination Information Form

The CETIF records client demographic information. Data fields must be complete and accurate. As data is changed or updated, a new hard copy must be printed and filed chronologically in the record.

References: MSSP Site Manual and MSSP Contract.

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

II. C. Notification of Rights

MSSP sites must inform clients and/or their designees of their right to be informed of MSSP components which are material to a client's participation (or lack of participation) in the MSSP. Program components include:

1. Processes on registering complaints, termination and appeal;

2. The safeguarding of client information (including application, care plan and termination form) through proper use of the AUDPHI Form and storage of client records;

3. Services that may be provided by MSSP as well as alternatives to participation in the program;

4. Potential outcomes of refusing offered services; and

5. Client participation in MSSP care planning and service satisfaction surveys.

Notices of Action (Termination and Change):

- State law and Medi-Cal regulations require that a Notice of Action (NOA) be sent to an applicant who is denied eligibility at point of application or to a MSSP client who has a change in service or who is terminated (for codes specified in the Site Manual) from the program. Timeframes for mailing NOAs are specified in the Site Manual. The NOA informs the applicant/client of rights to a fair hearing if they are dissatisfied with the termination action, change in services, or denial of entry into the MSSP. A copy of the NOA will be filed in the client's case record.

Client Rights/Right to State Hearing:

- Clients will be informed in writing and in a timely manner of their right to request a State Medi-Cal hearing when they indicate disagreement with any decision, which would result in a discontinuance, termination, suspension, cancellation or decrease of services under the program.

Reference: MSSP Site Manual and California Welfare and Institutions Code

Findings:

A termination NOA found in client record #XXXX was dated XXXX XX, XXXX and mailed to the client informing them they had been terminated from MSSP as of XXXX XX, XXXX. The client had XXXX XXXX .

A termination NOA dated XXXX , XXXX mailed to client #XXXX informing the client they had been terminated from MSSP effective XXXX, XXXX. The client was found to be no longer XXXX XXXX. The termination date on the CETIF was also XXXX, XXXX however the progress notes indicated a termination date of XXXX, XXXX. It was unclear what the actual termination date was or if the ten day requirement had been followed.

Client #XXXX was XXXX on XXXX, XXXX. The client was XXXX from the XXXX and terminated from MSSP on XXXX, XXXX. This timeframe is not considered prompt initiation of the termination process. Progress note documentation did not provide an explanation of why termination was delayed.

Recommendations:

Incorporate the following TA into site policies and procedures.

Technical Assistance:

Review MSSP Site Manual Section 6.400 Notice of Action for Terminations which states a NOA to a client who has moved out of the area does "…not need to meet the ten-day requirement, but must be mailed before the effective date of the termination action."

MSSP Site Manual Section 6.400 also includes NOA requirements when a client retains eligibility for Medi-Cal, but the basis for that eligibility changes to an aid category that no longer qualifies for MSSP. A NOA with a ten-day notice period is required for this termination reason.

Review MSSP Site Manual Section 3.1210 No Waived Services Provided During Institutionalization which states, "If it appears that the client will be placed long term (more than 30 days), termination procedures should be promptly initiated (10 day notification required; see Section 6.400, Notice of Action for Terminations)."

Corrective Action:

The findings did not constitute trends; therefore, a CAP is not required.

II. D. Authorization for Use and Disclosure of Protected Health Information Form

MSSP sites must comply with contract requirements regarding client confidentiality. Sharing and obtaining information requires specific client consent as provided in the AUDPHI. This form must:

- Address only one individual or agency;
- Be specific as to the particular information (such as diagnosis, treatment, or financial information) that is requested from/to that entity; and

- Include an expiration date which cannot exceed two years from the date of the client's signature.

References: MSSP Site Manual and MSSP Contract

Findings:

Seven of twenty client records (#XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) contained AUDPHIs that lacked the Care Managers (CM) dated signature.

Client record #XXXX lacked the date the client signed an AUDPHI.

Client record #XXXX contained an AUDPHI designating the protected health information to be disclosed as "XXXX" however the form did not specify what XXXX information was to be disclosed.

An AUDPHI was not found for the XXXX, who was present during the XXXX XXXX Reassessment for client #XXXX.

Recommendations:

Incorporate the following TA into site policies and procedures.

Technical Assistance:

The site was instructed to sign and date all AUDPHIs. The form may be revised to add a staff signature/date line or staff may sign and date on the line titled "witness".

Review MSSP Site Manual Section 5.810 Staff Signatures and Signature Requirements which states, "All documents contained in the case record required by either the site or the CDA/MSSP must be complete, including name (signature) of the person responsible for the form completion. Whenever there is a signature required in the case record it must be written (not printed) in ink and include the following:

- The individual's full name or first initial and full last name.
- The person's professional initials (e.g., RN [Registered Nurse], MSW [Master of Social Work]). If there is no professional title (CM without advanced academic degree(s) but with qualifying experience) the staff person may use the MSSP job classification title (e.g., SWCM). Agency staff may also use their appropriate agency job title initials.
- The signed document or recording must be dated."

AUDPHIs must be fully completed before the client's signature is obtained. When choosing "Other" as the type of information to be disclosed, "Other" must be further specified.

Information discussed during a Reassessment is considered protected health information. Review MSSP Site Manual Section 3.510 Confidentiality which states, "…sharing and obtaining information requires the specific consent of the client."

Corrective Action:

The findings did not constitute trends; therefore, a CAP is not required.

II. E. Institutionalization Form

Information regarding a client's admissions to a hospital (in-patient and out-patient) or nursing facility and emergency room visits are to be recorded on the IF. MSSP sites are responsible for the inclusion of the IF in the client case record. The IF provides a chronology of the client's hospitalizations and admitting diagnoses.

Reference: MSSP Site Manual

Findings:

Three of twenty client records were missing entries on the IF.

Recommendation:

The site must incorporate the following TA into site policies and procedures.

Technical Assistance:

Review MSSP Site Manual Section 3.2110 Institutionalization form which states, "Information regarding a client's admissions to a hospital (in-patient and out-patient) or nursing facility and emergency room visits are to be recorded on the Institutionalization Form (Appendix 23). This form is designed to consolidate information regarding institutionalizations in order to facilitate identification of health issues and events for care management purposes."

Corrective Action:

The findings did not constitute trends; therefore, a CAP is not required.

III. APPROPRIATENESS OF SERVICES

The criteria for Appropriateness of Services address the client's need for and ability and willingness to participate in the care management process. Both elements must be present.

- "Need for care management" is indicated when a client requires assistance to: gain access to community services (whatever the funding source); maintain or effectively utilize available services; or manage serious health conditions.

- "Ability and willingness to participate" is indicated by the client's cooperation in formulating and then carrying out the care plan. The term "client" includes a client's significant support person when the client is cognitively unable to participate independently.

It is important to confirm and document a new client's perception of why they were referred to the program, and how they characterize their situation, needs and goals. This would logically occur during either the screening or the assessment process. Differences in perceptions between the referral source, the client and the CM must be identified, acknowledged and addressed in the initial assessments.

References: MSSP Site Manual and MSSP Contract

III. A. Initial Health Assessment, Initial Psychosocial Assessment, and Reassessment

Assessment is the foundation of the care management process. Each person determined to be eligible through the MSSP intake screening process will receive face-to-face comprehensive IHA and IPSAs to determine specific problems, resources, strengths, needs and preferences and to confirm LOC.

Reassessment is a formalized method of documenting and analyzing changes during the period since the previous assessment, re-establishing eligibility as it relates to LOC and assuring that the client's needs are being met. Changes since the last assessment, as well as over a longer span of time, are particularly relevant.

Assessment instruments and forms include but are not limited to:

- IHA and IPSA
- Reassessments
- Summaries and Problem Lists
- Client's Medication List
- Client's Physicians and Other Health Professionals
- Initial Psychosocial Functioning
- CDA Approved Cognitive Screening Tool
- FNAG

References: MSSP Site Manual and MSSP Contract

Findings:

Four of twenty client records contained assessments that were incomplete or unclear as follows:

- "XX" was found next to "XXXX" in the equipment needs section of the FNAG in the XXXX XXXX for client #XXXX. The FNAG is designed to designate which items the client has and which ones they need. Entering "yes" or "no" has been recommended. In entering "XX" it was unclear if the client had a XXXX XXXX or needed one.

- The XXXX XXXX section of the IPSA, equipment check list was incomplete in client record #XXXX.

- The XXXX XXXX XX, equipment needs section of the FNAG was incomplete in client record #XXXX. It was unclear if the client had or needed all items listed.

- The problem list was missing from the IHA and the IPSA in client record #XXXX. The Vital Signs section of the IHA, "XXXX XXXX XXXX XXXX" was blank.

The XXX was completed XX days after the 2 week deadline without an explanation why in the progress notes.

Recommendations:

Incorporate the following TA into site policies and procedures.

Technical Assistance:

The equipment needs section of the FNAG requires a "YES" or "NO" answer. For example, if a client does not have or does not need a bedside commode, the response for "HAS" and "NEEDS" would be "NO" and "NO" respectively.

Review MSSP Site Manual Section 3.620 Assessment/Initial Assessments which states, "All sections are to be completed. If information is unobtainable for some reason, the situation should be noted on the form. On occasion, completion of an item may be deferred. Deferring an entry means that it will be completed later; it does not mean eliminating or not attempting to get the information at all. If completion of an item is deferred, the reason will be noted along with any plans for obtaining the information at a later time."

Also found in Section 3.620, assessments "…do not have to be completed in any particular order, however the first one is to be done within two weeks of the date of enrollment, and the other within two weeks of the first one. If this timeframe cannot be met, the reason for the delay must be documented in the client's progress notes."

Corrective Action:

The findings did not constitute trends; therefore, a CAP is not required.

III. B. Care Plan

Care planning is the process of developing an agreement between the client and CM regarding identified client problems and resources, outcomes to be achieved and services to be pursued in support of goal achievement. The care plan must reflect services and supports necessary to sustain the client's ability to live in their community. The care plan provides a focus for the needs identified in the functional assessments, organizes the service delivery system to the client and helps to assure that the service being delivered is appropriate to the client's needs/problem.

The MSSP interdisciplinary care management team will develop a client-centered written comprehensive care plan for each client. It will be based on the IHA and IPSA or reassessment findings, reflect all appropriate client needs, encompass both formal and informal services and will be written within two weeks of the latest assessment or reassessment.

The MSSP Care Plan includes:

- Statements of problems and needs determined upon assessment;
- Strategies to address the problems and needs; and
- Measurable goals or outcomes used to demonstrate resolution based upon the problem and need, the time frame, the resources available, and the desires and the motivation of the client and/or family.

References: MSSP Site Manual and MSSP Contract

Findings:

Sixteen of twenty client records (#XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) contained goals on the care plans that either lacked measurability, were difficult to measure or included interventions within the goal statement.

Twelve of twenty client records (#XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) contained problem statements that did not fully describe the client's functional limitations therefore, the need for services was not substantiated.

Client record #XXXX contained a problem statement that was not client centered.

Ten of twenty client records contained needs identified during assessments that were not included on the care plan as follows:

- #XXXX - a XXXX, XXXX XXXX and a device to XXXX XXXX,
- #XXXX – a client XXXX while XXXX,

- #XXXX – XXXX, XXXX XXXX, loss of fine XXXX XXXX XXXX, XXXX XXXX, XXXX, XXXX with an XXXX XXXX and XXXX XXXX XXXX,

- #XXXX – XXXX, XXXX, XXXX, XXXX, XXXX, and difficulty XXXX XXXX XXXX XXXX in the XXXX,

- #XXXX – XXXX, XXXX XXXX, XXXX and XXXX XXXX,

- #XXXX and #XXXX – do not meet the overall needs of the clients,

- #XXXX – XXXX and XXXX XXXX XXXX,

- #XXXX – XXXX, and

- #XXXX – XXXX, XXXX, a XXXX XXXX and a XXXX XXXX.

Progress notes did not include documentation of why identified needs were excluded.

Services were provided for clients that were not included on the care plan as follows:

- #XXXX – XXXX and XXXX, and

- #XXXX – XXXX of XXXX XXXX in XXXX area.

Five of twenty client records lacked a complete list of interventions to address the client's needs as follows:

- #XXXX, #XXXX and #XXXX – XXXX (XXXX) was the only intervention for a client at risk for XXXX,

- #XXXX – interventions that did not address the issue (e.g. client with XXXX and XXXX, a history of XXXX and a continued XXXX XXXX contained the intervention "Monitor XXXX & XXXX"),

- #XXXX – one intervention per problem statement, to obtain an XXXX.

Three care plans were completed beyond the two week due date in client records #XXXX, #XXXX, and #XXXX. Progress notes did not include documentation as to why the care plans were not completed timely.

The care plan for client #XXXX was not updated or revised when XXXX XXXX began.

The XXXX / XXXX for client #XXXX provided informal services, including XXXX and XXXX, were excluded from the care plan.

Recommendations:

Incorporate all TA provided during the review and in this report into site policies and procedures. Conduct a training session within 60 days from the date of this report to ensure the care plan process is followed according to program requirements. Submit to CDA the curriculum used, name of the person conducting the session, and a list of attendees.

Sixty (60) days following the care plan training, the site will submit to CDA for review, one care plan from each CM along with the associated re/assessment summary. The care plans will be reviewed by CDA and additional technical assistance will be provided, as necessary.

Technical Assistance:

Review MSSP Site Manual Section 3.640 Care Planning which states, the MSSP care plan includes measurable goals or outcomes used to demonstrate resolution based upon the problem/need, the time frame, the resources available, and the desires/motivation of the client/family.

Review MSSP Site Manual Section 3.640.3 Care Plan Components which states, "The goal is the desired end result to be achieved. The goal will specify the skills to be acquired, behaviors to be changed, information to be provided, health or psychosocial conditions to be met. The outcome identifies the anticipated result or benefit to be obtained from the service provided."

Goals must be specific, measurable, attainable and realistic. Goals do not contain interventions.

The goal for Problem Statement X on the XXXX XXXX care plan for client #XXXX was:

- "Client will receive XXXX and XXXX paid by Medi-Cal."

This goal is not measurable. It also includes the intervention "XXXX." This goal also does not address the actual problem statement, that the client has XXXX XXXX XXXX and is at risk for XXXX XXXX.

An example of a measurable goal to address this issue is:

- *Client will report her XXXX is XXXX and XXX is free of all XXXX of XXXX XXXX during each monthly contact.*

Goal statements are difficult to measure when using terms such as "adequate," "reduce," and "regular." A goal for client #XXXX was:

- "…client will have adequate XXXX and XXXX…"

A method to measure whether XXXX and XXXX is adequate is to ask the client to report during monthly contacts if their XXXX needs are being met on a daily basis.

Review MSSP Site Manual Section 3.640.3 Care Plan Components which states, problem statements must describe areas of concern identified in the re/assessment. They must define the problem and substantiate the need for the service. Problem statements are derived from problem lists, written in complete statements, are client centered and relate to the client's functional status. Problem statements do not include interventions.

Problem Statement XX from the XXXX XXXX care plan for client #XXXX was:

- "Client is unable to complete own XXXX XXXX or do any XXXX, XXXX or XXXX."

This problem statement describes the need but does not relate the need to the client's functional limitations in order to substantiate a need for services. An example of a problem statement for this issue is:

- *Client with XXXX and XXXX is unable to complete XXXX XXXX and XXXX.*

Review MSSP Site Manual Section 3.640 Care Planning which states "The MSSP interdisciplinary care management team will develop a client-centered written comprehensive care plan for each client. It will be based on health and psychosocial assessment or reassessment findings, reflect all appropriate client needs, encompass both formal and informal services, and will be written within two weeks of the latest assessment or reassessment. Any needs or services deferred must have appropriate justification for the deferral documented in the client record. The methods of addressing or attenuating any risk associated with the deferral must be documented and followed up on a timely basis."

Review Site Manual Section 3.640.3 Care Plan Components which states, the intervention section "…outlines possible actions, plans or solutions to solve the problem."

Interventions address the client's needs and relate specifically to accomplishing the goal. Language must imply some action such as "refer," "assist," "arrange," "purchase," "advocate," "obtain," or "monitor."

The health and safety of our clients is of utmost importance. A client at risk for falls has the potential for health decline or hospitalization if a fall occurs. We must do everything in our power to prevent falls. Although an ERS device is an appropriate intervention to address the issue of fall risk, it must not be the only intervention. An ERS device does nothing to prevent falls. It is only helpful once a fall has occurred to access emergency services. Interventions that could be included to address falls are:

- *Complete a MSSP Fall Risk Assessment tool (Appendix 21g)*
- *Coordinate with MD re: Referral for OT and PT evaluations and DME prescriptions from recommendations*
- *Arrange OT and PT services for strength training and gait balance*
- *Coordinate with DME provider to obtain recommended equipment via Med89Cal TAR (list specific equipment recommended)*
- *Monitor monthly for falls and appropriate use of equipment in place*
- *Encourage client to remove loose/throw rugs from home*
- *Provide ongoing fall prevention education*
- *Coordinate ramp installation to ensure easy access into and out of home*
- *Purchase ERS device to common help in case of falls*

Review MSSP Site Manual Section 3.640.8 Changes to the Care Plan which states, "Care plan documents (i.e., the care plan and SPUS) must be updated/revised when warranted by changes in the client's condition, goals or service needs. Clients will participate in any discussion or plans regarding any changes to their care plan. This participation will be reflected in the progress notes."

A hand-out was provided with examples of problem statements, goals, service providers and interventions addressing common issues found in the majority of client records reviewed.

The site was made aware of a local fall prevention program, "Fitness On the Move," which provides in home personal training for fall prevention.
Corrective Action:

A CAP is required.

III. C Assessing and Documenting Client Risk

The goal of risk assessment is informed by the fact that MSSP clients have the right to refuse specific services and interventions. When a client refuses a service or intervention, the site must have a process of assuring that the risks associated with the refusal are addressed to the extent possible.
Assessing a client's ability to assume risk includes whether or not the client can:

- Make and communicate choices;
- Provide sensible reasons why choices were made;
- Understand the implications of choices; and
- Consider the consequences of choices.

A risk management plan will be developed when a situation arises where the client has chosen a course of action that may place the client at risk. This process allows for the systematic exploration of situations with a high possibility of an adverse outcome.

The status of the risk management plan must be monitored during regular monthly contacts by the CM. It must be formally reviewed or renewed at intervals mutually agreeable to the client and CM.

Reference: MSSP Site Manual

Findings:

Client record #XXXX contained documentation that the client was XXXX while XXXX XXXX in the home. No documentation was found that education had been provided regarding the dangers of XXXX while XXXX. This issue was not included on the care plan and a negotiated risk management plan was absent from the record. A referral to XXXX (XXXX) was not found in the record. Documentation did not provide any plan to mitigate the situation.

This situation is a serious safety risk and poses a threat to the client's life and endangers those in close proximity. CMs are mandated reporters and must report any critical incidences and outcomes to CDA and to the appropriate agencies. (e.g. XXXX).

The interdisciplinary team must form and carry out a plan to ensure the safety of the client. Documentation must include a description of the situation, including that the client was informed of the possible consequences of their decision, an evaluation of the client's ability to assume risk, solutions offered by the CM to minimize the potential risk, the possible negative consequences, the client's preferences and a description of the services or interventions that will be provided to accommodate the client's choice or minimize the potential risk.

Recommendations:

Incorporate the TA provided during the review and in this report into site policies and procedures. Conduct a training session within 60 days from the date of this report to ensure that the assessing and documenting client risk process is followed according to program requirements. Submit to CDA the curriculum used, name of the person conducting the session, and a list of attendees.

Technical Assistance:

Review MSSP Site Manual Sections:

- 3.710 Goal of Risk Assessment
- 3.702 Assessment of Ability to Assume Risk,
- 3.730 Risk Management Planning and
- 3.740 Monitoring of Risk.

Hand-outs provided included: “XXXX XXXX” and “XXXX XXXX.”

Following the UR, CDA reviewers found these publications, which mitigate XXXX, were developed for use in XXXX. Further research, found that California authorities, particularly the XXXX XXXX (XXXX XXXX), strongly warns, “XXXX XXXX XXXX.” This pertains to XXXX XXXX like XXXX and XXXX as well. XXXX surfaces XXXX heightened XXXX XXXX even after the XXXX source has been XXXX XXXX. This information will be forwarded to the site.

Corrective Action:

A CAP is required.

III. D. Progress Notes

Progress notes are the ongoing chronology of the client’s events and care management. They must address: health and safety issues; the provision of services as planned; whether services continue to be necessary and appropriate; whether they are being delivered as anticipated; and the client’s response to the service. Notes shall include the following, as appropriate:

- The date and type of MSSP staff contact with the client;
- A record of all events that affect the client and the status or validity of the care plan;
- Actions taken when there are discrepancies between the care plan and services delivered;
- Any education or counseling support provided to either the client or caregiver;
- Evaluative subjective and/or objective comments on all services delivered and client outcomes in relation to needed services; and
- A reflection of the relationship between identified problems and services delivered or not delivered.

Progress notes must include any significant information regarding the client's relationship with family, community or any other information which would impact the established goals for the client's independent living.

Reference: MSSP Site Manual

Findings:

Thirteen of twenty client records (#XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) lacked documentation of care management activity.

Eight of twenty client records (#XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) contained progress notes that were incomplete. Progress notes did not provide a clear sequence of events or a description of the client's status.

Progress notes in client record #XXXX did not address all care plan problem statements in the month of XXXX.

Client record #XXXX lacked documentation that XXXX XXXX XXXX had been provided to the client.

A quarterly home visit was missed in client record #XXXX.

The staff title was missing from the signature in progress notes for client #XXXX.

Recommendations:

Incorporate the TA provided during the review and in this report into site policies and procedures. Conduct a training session within 60 days from the date of this report to ensure that progress note documentation is followed according to program requirements. Submit to CDA the curriculum used, name of the person conducting the session, and a list of attendees.

Technical Assistance:

Review MSSP Site Manual Section 3.820 What Progress Notes Include which states, "Progress notes are the ongoing chronology of the client's events and care management. They must address: health and safety issues; the provision of services as planned; whether services continue to be necessary and appropriate; whether they are being delivered as anticipated; and the client's response to the service. Notes shall include the following, as appropriate:

- Progress notes must address and document each problem listed in the CP, including the month of Reassessment;
- The date and type of MSSP staff contact with the client (whether the contact was a home visit or telephone call will be specified);
- A record of all events that affect the client and the status or validity of the CP (e.g., hospitalization, collateral contacts with other agencies);
- Any education or counseling provided to the client or caregiver to ensure that the needs of the client are met;

- Actions taken when there are discrepancies between the care plan and services delivered."

Lack of progress note documentation can be subject to recovery.

Quarterly face-to-face visits are required every three months. If a visit is missed or delayed, progress notes must explain the reason.

Review MSSP Site Manual Section 5.810 Staff Signature and Signature Requirements which states that all documents, including progress notes, requiring a staff signature will include the full name or first initial and full last name of the person completing the form, their professional initials (e.g., RN [Registered Nurse] and the date.

Corrective Action:

A CAP is required.

III. E. Case Record

MSSP sites must maintain up-to-date, centralized, confidential and secured case file records for each MSSP client, utilizing mandatory CDA forms. Sites are to implement case documentation, date and signature requirements, revisions and corrections according to the MSSP Site Manual specifications and time frames.

Case record documentation is a tangible part of the care management process which must be clear, timely, accurate, legible, appropriate and complete, providing the CM with working documents that are effective and efficient. The site shall also maintain and make available records for inspection and audit by the State.

Reference: MSSP Site Manual

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

IV. AUTHORIZATION AND UTILIZATION OF SERVICES

MSSP sites are responsible for maintaining complete records for funds received under the MSSP contract, including the tracking for purchased and referred services. Sites are required to cooperate with the State in the monitoring, assessment and evaluation of site processes. Sites must provide the CDA any relevant information requested through ad hoc reports that are related to administrative procedures.

The Department's Audit Branch will review the reconciliation process between service authorization and disbursement of payments to ascertain whether services authorized and provided were:

- Consistent with the care plan,
- Verified by the site, and
- Differences between authorized and verified services noted.

CDA MSSP staff will review selected client records to verify that correct procedures were followed in authorizing services for clients.

In authorizing services for a client, the CM will use the following prescribed order of priorities:

1. All services available through the informal support of family, friends, etc., must be used.

2. Existing Title XVIII Medicare, Title XIX Medi-Cal, Title XX Social Services, Title III Older Americans Acts, the Special Circumstances Program, and other publicly-funded services for which the client is eligible, and which are available in the community, must be relied upon, coordinated and recorded in developing a care plan. Within MSSP these services are called "Referred" services.

3. Only after the client's informal support and the existing public and private services are reviewed and optimally used, can the CM request the use of MSSP funds to purchase Waived Services. Within MSSP, these services are also called "Purchased" services.

CMs must be aware of the cost associated with maintaining a client in MSSP. When considering the acquisition of a piece of client equipment, e.g., emergency response device or non-medical home equipment, it is important to analyze both the purchase and rental options to determine the most cost-effective approach.

References: MSSP Site Manual and Contract

IV. A. Service Planning and Utilization Summary

The SPUS is an element of the client's care plan. The SPUS sets forth specific service information: who is the provider, what service is provided, how much it will cost, and what is the source of payment.

The SPUS is to be completed for each client for each month they are enrolled in the program. The services tracked on the SPUS are those purchased with waived services funds and certain categories of services obtained by referral to other funding sources.

The primary CM signs each client's verified SPUS each month. If the client's tracked costs are more than 95%, but less than 120%, of the site's benchmark, the Supervising CM must also sign; if costs exceed 120%, the Site Director must sign the SPUS, too.

References: MSSP Site Manual and Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

IV. B. Tracking Cost Effectiveness

In addition to care management services provided by the MSSP site staff, the program is authorized to purchase supportive services from the list of approved Waived Services.

MSSP CMs are required to follow service authorization procedures which maximize the use of the informal support system and existing community service delivery systems (including use of the Medi-Cal Treatment Authorization Request [TAR] process) prior to the use of Waived Services.

References: MSSP Site Manual and Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

IV. C. Vendor Agreement Review

Sites are responsible for arranging for the provision of client services. In addition to the MSSP Site Manual, there are two documents that must be consulted in this regard: the current MSSP Waiver and the individual site contract with CDA. Both the Waiver and the contract set forth policy and procedures which must be followed in structuring the terms and conditions of agreements with local service providers. In the contract, the site agrees to directly provide or arrange for the continuous availability and accessibility of all services identified in each client's care plan. In addition, the site agrees to maintain sufficient written vendor agreements for the following minimum array of Waived Services at all times.

(a) Adult Day Support Center (ADSC) and Adult Day Care (ADC)
(b) Housing Assistance
(c) Domestic Chore and Personal Care Services
(d) Care Management
(e) Respite Care
(f) Transportation
(g) Meal Services
(h) Protective Services
(i) Special Communications

Sites are required to maintain specific information and documents on each vendor of services. Sites must maintain copies of current license and insurance documents, and establish a tickler file or other system to ensure timely updating of this information. The Vendor Record Review Tool can assist sites with maintaining service provider compliance to MSSP requirements.

References: MSSP Site Manual and Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

V. QUALITY ASSURANCE ACTIVITIES

Quality assurance (QA) is characterized by a focus on systems, processes and outcomes, rewarding excellence, and working in a collaborative or partnership environment. It is ongoing, with each element continuously informing and supporting

the entire process. Rather than replacing traditional program evaluation activities, quality assurance builds on and integrates them into an organized system.

MSSP sites are required to deliver quality services to clients through the continual demonstration of best practices in clinical care management. Sites will have a written policy describing their QA activities that includes a vision/mission statement, which ensures that staff fully support the mission and specifies the elements employed to secure this vision. QA elements include, but are not restricted to, a process of peer/internal review and a means to solicit client satisfaction with MSSP services.

V. A. Peer/Internal Review

Peer/Internal Review activities focus awareness on care management activities practiced within the program. Driven by the needs and abilities of the care management staff, this review process offers CMs an opportunity to learn from each other through the critical examination of professional practices.

References: MSSP Site Manual and MSSP Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

V. B. Client Satisfaction

Client Satisfaction Surveys, or other methods of obtaining information regarding client satisfaction, are instrumental to program operation analysis and the provision of quality client services.

References: MSSP Site Manual and MSSP Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

V. C. Home Visit

A home visit to a client ensures that clients are informed of their rights and receive quality services that meet their needs.

References: MSSP Site Manual and MSSP Contract

Home Visit Summary

The CDA Nurse Evaluator and a site NCM made a home visit to client #XXXX on XXXX, XXXX X, 2010. The client was an XX year old XXXX who lives in a XXXX home with XXX XXXX XXXX who is XXXX XXXX XXXX. The client greeted XXX CM with a hug and invited us into XXX home. The client's medical history included XXXX XXXX XXXX with a XXXX XXXX, XXXX XXXX XXXX , XXXX with XXXX XXXX XXXX in the XXXX XXXX, XXXX, XXXX and XXXX.

The client provided the name of XXX XXXX and stated XXX is very happy with the services XXX provides. The NCM reviewed the care plan with the client. No new needs were identified. The client stated XXX is happy with the program and how XXX is treated by XXX CMs.
The client stated XXX was aware of XXX rights as a participant in the program. XXX could not think of anything that might make the program better, but asked if we could do anything to stop the XXXX XXXX from XXXX.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

VI. BEST PRACTICES

Best Practices are those processes, policies, procedures and methods of casework that demonstrate exemplary work in the field of care management. Examples of Best Practices include, but are not limited to, administrative processes, the work done within an individual case, and general practices developed and applied to the work of all site care management staff.

The review team would like to acknowledge the site for the following examples of Best Practices:

1. Use of a Disaster Response Senior or Disabled Registry Form which provides emergency contact information, directions to the client's home, whether the client lives alone and has any pets and specific health issues related to disabilities.

2. The number of home visits is beyond the quarterly requirement exhibiting concern for the client's welfare and promotes the client/CM relationship.

3. The multidisciplinary team approach is beyond requirements showing excellent collaboration not only within the MSSP site, but in the community as evidenced by the donations received from various community resources.

VII. SUMMARY

The site is acknowledged for its hospitality and for being receptive to the recommendations made and the TA provided during the UR process. This review team is available to provide continued technical support regarding the findings identified in this report.